South Carolina Department of Labor, Licensing and Regulation
South Carolina Board of Medical Examiners
P.O. Box 11289 • Columbia, SC 29211
Phone: 803-896-4500 • Fax: 803-896-4515 • www.llronline.com/POL/Medical

APPLICATION FOR RENEWAL OF LIMITED LICENSE

NOTE: Application must be fully completed with all requested information and documentation supplied. A copy of your training contract and application fee of **$150.00** (**$75.00 six months**)(**non-refundable)** must accompany this application.

I hereby make application to renew my current Limited License in the state of South Carolina and submit the following statement of facts with the required supporting documents. *The application form itself is a public document obtainable under the Freedom of Information Act*.

(Please type or print clearly)

Applicant's Name _____
Last First Middle

Home address: South Carolina practice information:

_____ _____ _____
Street address Hospital

_____ _____
City State Zip Street address

(_____)_____ _____
Home telephone number City State Zip

_____ (_____)_____
*Social Security Number Office telephone number

Date of Birth _____ Type of training/practice_____
Month Day Year

SC Limited License Number_____

*The Social Security Number (SSN) is not subject to disclosure as public information. The disclosure of the SSN for identification purposes is authorized and mandated by federal statutes requiring state medical boards to report to the Healthcare Integrity and Protection Data Bank (HIPDB) and the National Practitioner Data Bank (NPDB), among other things.

(Rev.2/12)

CONTROL# _____
CHECK# _____
AMOUNT $_____

PERSONAL DATA

**** If you are currently enrolled in the Recovering Professional Program (RPP), you may answer "No" to this question**.

Since you last applied with this office for your Limited License: Answer Yes or No

1. Has your medical license been revoked, suspended, reprimanded, restricted or placed on probation by any medical licensing board or other entity? _____

2. Have you had an application to practice medicine denied or refused by another medical licensing board or entity? _____

3. Have you had hospital privileges denied, revoked, suspended or restricted in any way? _____

4. Have you voluntarily surrendered a medical license, controlled substance registration or DEA registration? _____

5. Have you resigned from any hospital, institution or health care facility in lieu of disciplinary action? _____

6. Are you currently under investigation or the subject of pending disciplinary action by any medical licensing board, health care facility or other entity? _____

7. Is your medical license currently restricted in any way by any medical licensing board, or other entity? _____

8. Have you had a malpractice lawsuit, judgment or settlement filed against you? If so, how many? _____

9. Have you been treated for any physical, mental, or emotional condition that might interfere with your ability to competently and safely perform the essential functions of practice as a physician?** _____

10. Have you developed any disease or conditions, physical, mental or emotional, (e.g. bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder) that might interfere with your ability to competently and safely perform the essential functions of practice as a physician?** _____

11. Has your ability to practice medicine ever been impaired by any physical or mental illness or by the use of alcohol or drugs? _____

12. Have you discontinued the practice of medicine for any reason for one month or more? _____

13. Has your ability to prescribe controlled substances been denied, revoked, suspended or limited by any hospital, health care facility or other entity? _____

14. Have you been arrested, indicted, or convicted, pled guilty or pled nolo contendere for violation of any federal, state or local law(other than a minor traffic violation)? _____

15. Have you ever been known by any other name or surname? _____

NOTE: If you answered "Yes" to any of the above questions (1-15), you must attach a full written explanation pertaining to that particular question.

I have carefully read all questions in this application and have answered them fully, accurately, and completely. I hereby agree that my failure to answer all questions or make full disclosure of any facts or information called for in this application shall constitute cause for the denial of my application or for the revocation of my license to practice medicine in South Carolina. I hereby authorize the Board of Medical Examiners of South Carolina to utilize my Social Security Number in making necessary reports to the Federation of State Medical Boards' Physician Data Center for compilation of information about applicants and licensees in order to coordinate licensure and disciplinary activities between the individual States' licensing boards, and to federal and state entities, as required by law.

Applicant's Signature_____ Date_____